

2013 Retiree Coverage Election Form

- List eligible family members you wish to cover or remove from coverage. This form replaces all *Retiree Coverage Election Forms* previously submitted.
- If deferring PEBB retiree coverage, complete sections 1, 7 and 8 if applicable, and 9.
- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- If adding a dependent with a disability age 26 or older, or an extended dependent, attach appropriate dependent certification form(s). Forms are available at www.pebb.hca.wa.gov or by calling 1-800-200-1004.
- If you are a non-Medicare retiree and adding a family member, you must provide proof of eligibility within PEBB's enrollment timelines or the family member will not be enrolled. A list of documents we will accept to show proof of eligibility is in the *Retiree Enrollment Guide* and available at www.pebb.hca.wa.gov under *Dependent Verification*.
- If you are a surviving spouse, state-registered domestic partner, or dependent, provide the social security number (SSN) of the deceased retiree or employee in the "Retiree or employee information only" section below. Provide **your** SSN in "Section 1: Subscriber Information."

Check One	<input type="checkbox"/> I am a new retiree or a surviving dependent		
	<input type="checkbox"/> I am changing an existing account		
	<input type="checkbox"/> I am eligible under Plan 3, not retiring		
Retiree or employee information only	Retiree or employee name		
	Social security number	Retirement Plan	Retirement date (mm/dd/yyyy)
For K-12 school district retirees only	School district		
	When does your current school district medical/dental coverage end? (mm/dd/yyyy)		
Enrollment after deferral	Date other coverage ended (mm/dd/yyyy)		

Section 1: Subscriber Information					
Social security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Street address	Apt./unit number	City	State	ZIP Code	
Mailing address (if different than above)	Apt./unit number	City	State	ZIP Code	
County of residence	Date of birth (mm/dd/yyyy)	Daytime phone number (including area code) ()	Home phone number (including area code) ()		

(this section continued on next page)

2013 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social security number
------------------------	------------	----------------	------------------------

Section 1: Subscriber Information *(continued)*

Election Check the boxes that apply to you.

☐ **Enroll:** ☐ Medical only ☐ Medical and dental

☐ **Cancel coverage.** I understand that I am forfeiting all further rights to enroll in the PEBB Program unless I regain eligibility. Cancel date: _____

☐ **Defer my coverage.** Identify below your medical coverage that allows you to defer PEBB retiree coverage. **See also Section 9. Except as stated below, this defers coverage for all family members.**

Deferral date _____

☐ **Enroll (after deferring coverage).** Identify below the medical coverage you have been enrolled in since deferring enrollment in PEBB retiree coverage. **You must provide proof of continuous coverage since your date of deferral (begin and end dates).**

Date other coverage ended _____

If deferring or enrolling, check the box below that applies to you:

- ☐ Enrolled in a PEBB or Washington State K-12 school district-sponsored medical plan as a dependent.
- ☐ Enrolled under another comprehensive, employer-sponsored medical plan as an employee or dependent, including insurance coverage continued under COBRA.
- ☐ Enrolled in medical coverage as a retiree or dependent in a federal retirement plan, such as TRICARE.
- ☐ Enrolled in Medicare Part A and Part B, and a Medicaid program that provides creditable coverage. (You may continue to cover eligible family members who are not eligible for creditable coverage under Medicaid in a PEBB plan.)

Are you enrolled in Part(s) A and/or B of Medicare? If yes, attach a copy of your Medicare card to this election form if we don't already have a copy.

Part A (hospital) ☐ Yes ☐ No If yes, effective date _____

Part B (medical) ☐ Yes ☐ No If yes, effective date _____

Are you enrolled in Part D (prescription-drug coverage) of Medicare? ☐ Yes ☐ No If yes, effective date _____

Are you enrolled in Medicaid with Medicare Part D? ☐ Yes ☐ No If yes, effective date _____

Are you receiving Social Security Disability? ☐ Yes ☐ No If yes, effective date _____

Section 2: Spouse or State-Registered Domestic Partner Information

List an eligible spouse or state-registered domestic partner you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. **If you are a non-Medicare retiree adding a spouse or partner, you must provide proof of eligibility within PEBB's enrollment timelines or they will not be enrolled.**

Relationship to subscriber (If adding a state-registered domestic partner, please attach a completed *Declaration of Tax Status* form.)

☐ Spouse: date of marriage _____ ☐ Domestic partner: date registered _____

Social security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
------------------------	-----------	------------	----------------	--

Street address	Apt./unit number	City	State	ZIP Code
----------------	------------------	------	-------	----------

Date of birth (mm/dd/yyyy)	PEBB coverage for spouse/partner <input type="checkbox"/> Cover <input type="checkbox"/> Remove Effective Date _____ Reason _____
----------------------------	--

Enrolled in Part(s) A and/or B of Medicare? **Part A (hospital)** ☐ Yes ☐ No If yes, effective date _____

If yes, attach a copy of your Medicare card to this election form. **Part B (medical)** ☐ Yes ☐ No If yes, effective date _____

Enrolled in Part D (prescription-drug coverage) of Medicare? ☐ Yes ☐ No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D? ☐ Yes ☐ No If yes, effective date _____

Receiving Social Security Disability? ☐ Yes ☐ No If yes, effective date _____

2013 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social security number
------------------------	------------	----------------	------------------------

Section 3: Family Member Information (such as a child) *Use additional forms for more members.*

List eligible family members you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. **If you are a non-Medicare retiree adding a family member, you must provide proof of eligibility within PEBB's enrollment timelines or they will not be enrolled.** If adding a child of your state-registered domestic partner, also attach a Declaration of Tax Status form. Attach certification form(s) if enrolling a dependent with a disability age 26 or older, or an extended dependent.

1	Relationship to subscriber	Last name	First name	Middle initial						
Social security number	Date of birth (mm/dd/yyyy)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Disabled? (Check only if age 26 or older) <input type="checkbox"/> Yes <input type="checkbox"/> No							
Street address	Apt./unit number	City	State	ZIP Code						
PEBB coverage for family member <input type="checkbox"/> Cover <input type="checkbox"/> Remove Effective Date _____ Reason _____										
Enrolled in Part(s) A and/or B of Medicare? If yes, attach a copy of your Medicare card to this election form. <table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">Part A (hospital)</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>If yes, effective date _____</td> </tr> <tr> <td>Part B (medical)</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>If yes, effective date _____</td> </tr> </table>					Part A (hospital)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, effective date _____	Part B (medical)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, effective date _____
Part A (hospital)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, effective date _____								
Part B (medical)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, effective date _____								
Enrolled in Part D (prescription-drug coverage) of Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____										
Enrolled in Medicaid with Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____										
Receiving Social Security Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____										
2	Relationship to subscriber	Last name	First name	Middle initial						
Social security number	Date of birth (mm/dd/yyyy)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Disabled? (Check only if age 26 or older) <input type="checkbox"/> Yes <input type="checkbox"/> No							
Street address	Apt./unit number	City	State	ZIP Code						
PEBB coverage for family member <input type="checkbox"/> Cover <input type="checkbox"/> Remove Effective Date _____ Reason _____										
Enrolled in Part(s) A and/or B of Medicare? If yes, attach a copy of your Medicare card to this election form. <table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">Part A (hospital)</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>If yes, effective date _____</td> </tr> <tr> <td>Part B (medical)</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>If yes, effective date _____</td> </tr> </table>					Part A (hospital)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, effective date _____	Part B (medical)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, effective date _____
Part A (hospital)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, effective date _____								
Part B (medical)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, effective date _____								
Enrolled in Part D (prescription-drug coverage) of Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____										
Enrolled in Medicaid with Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____										
Receiving Social Security Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____										

2013 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social security number
------------------------	------------	----------------	------------------------

Section 4: Changes to an Existing Account

Are you making changes to an existing account? ☐ Yes **If yes, what changes?** (Check all that apply in the sections below.)
☐ No *If no, go to Section 5.*

Changes you can make anytime

- ☐ Name change ☐ Address change Give date of event/change _____
- ☐ Removing dependent(s). If removing due to loss of eligibility (divorce, dissolution of domestic partnership, death, or other loss of eligibility under PEBB rules), **you must submit this form no later than 60 days after the event.** If applicable, provide former dependent's new address:
- _____

Additional changes you can make if an event creates a special open enrollment

The PEBB Program will only allow changes outside of an annual open enrollment when an event creates a special open enrollment. The PEBB Program may request proof of the event that created the special open enrollment. You must submit this form **no later than 60 days after the event.** However, if adding a newborn or newly adopted child, and adding the child increases your premium, you must submit this form no later than 12 months after the birth or adoption.

Check the box(es) next to the change you are requesting, and indicate the corresponding event(s) below.

- ☐ Add dependent(s) ☐ Change medical and/or dental plan Give date of event _____

The following events also allow a subscriber to add a dependent and change a medical or dental plan:

- ☐ Marriage, registering a domestic partner, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- ☐ A court order or National Medical Support Notice requiring the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- ☐ Child becoming eligible as an extended dependent through legal custody or legal guardianship. *Also complete Extended Dependent Certification form. Forms are available at www.pebb.hca.wa.gov.*
- ☐ Child becoming eligible as a dependent with a disability. *Also complete Certification of Dependent with Disability form. Forms are available at www.pebb.hca.wa.gov.*
- ☐ Dependent losing other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- ☐ Subscriber or dependent having a change in employment status that affects the subscriber's or dependent's eligibility for the employer contribution toward group health coverage.
- ☐ Subscriber or dependent becoming eligible or losing eligibility for premium assistance through Medicaid or a state Children's Health Insurance Program (CHIP).

The following events allow a subscriber to add a dependent:

- ☐ Subscriber or dependent having a change in enrollment under another employer plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- ☐ Subscriber's dependent moving from outside the United States to live in the United States.

The following events allow a medical and/or dental plan change:

- ☐ Subscriber or dependent having a change in residence that affects health plan availability.
- ☐ Subscriber or dependent becoming entitled to Medicare, or enrolling in or cancelling a Medicare Part D plan.
- ☐ Subscriber or dependent's current health plan becoming unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA).
- ☐ Retiree experiencing a disruption of care that could function as a reduction in benefits for the subscriber or his or her dependent for a specific condition or ongoing course of treatment with approval by the PEBB Program.

2013 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social security number
------------------------	------------	----------------	------------------------

Section 5: Medical Plan Selection *Check only one.*

Contact plans for benefits information; their contact information is at the end of this form.

Group Health Cooperative¹

- ☐ Group Health Classic
- ☐ Group Health Medicare Plan²
- ☐ Group Health Value

Group Health Options Inc.

- ☐ Group Health Consumer-Directed Health Plan³

Kaiser Foundation Health Plan of the Northwest

- ☐ Kaiser Permanente Classic
- ☐ Kaiser Permanente Consumer-Directed Health Plan³
- ☐ Kaiser Permanente Senior Advantage¹

☐ Medicare Supplement Plan F, administered by Premera Blue Cross⁴

Uniform Medical Plan, administered by Regence BlueShield

- ☐ UMP Classic
- ☐ UMP Consumer-Directed Health Plan³

¹ These plans offer Medicare Advantage plans to Medicare enrollees in certain counties. Complete and attach the *Medicare Advantage Plan Election Form* (form C) if you live in a county where Medicare Advantage is available.

² If you cover family members not enrolled in Medicare, also select Group Health Classic or Group Health Value for your non-Medicare family members.

³ These plans are available only to retirees not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must cancel your dependent's PEBB coverage to enroll in this plan.

⁴ Also complete and return form B to enroll in Medicare Supplement Plan F. PEBB does not offer the high-deductible Plan F.

Section 6: Dental Plan Selection *Check only one. You must enroll in medical coverage to enroll in dental.*

If you select retiree dental coverage for yourself, you must keep dental coverage for at least two years. However, you may change retiree dental plans within those two years. Contact the plans for benefits information; their contact information is located at the end of this form.

Preferred Provider Organization

- ☐ Uniform Dental Plan, administered by Washington Dental Service (Group #3000)
(may receive services from any provider)

Managed-Care Plans

- ☐ DeltaCare, administered by Washington Dental Service (Group #3100)

Dentist name or clinic code _____
(must receive services from a DeltaCare provider)

- ☐ Willamette Dental of Washington, Inc.

Clinic location _____
(must receive services from a Willamette Dental Group plan provider)

☐ Cancel Dental

I understand that I may only cancel this coverage if I have maintained enrollment in a PEBB retiree dental plan for at least two years or if I am deferring or disenrolling from my PEBB account as allowed under PEBB rules (Section 9). If I cancel dental for myself, dental is automatically cancelled for my enrolled dependents.

2013 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social security number
------------------------	------------	----------------	------------------------

Section 7: Term Life Insurance Enrollment Information

Retiree Term Life Insurance is only available to those who received PEBB employee life insurance. You must apply for Retiree Term Life Insurance no later than **60 days** after your employer-paid coverage ends. The cost is \$6.57 per month (guaranteed through December 31, 2013), regardless of age.

Disabled retirees who qualify for the waiver of premium benefit under the PEBB employee life insurance plans are not eligible for this Retiree Term Life Insurance Plan.

Age at Time of Death	Under 65	65 through 69	70 and over
Amount of Coverage	\$3,000	\$2,100	\$1,800

Coverage has no cash value.

I elect to enroll in the PEBB Retiree Term Life Insurance Plan. ☐ Yes ☐ No

Beneficiary	Beneficiary's SSN
Relationship to retiree	Beneficiary's date of birth
Beneficiary's address	

Section 8: Authorization for Premium Payment

I authorize the Department of Retirement Systems to deduct from my retirement allowance the amount I am required to pay for this coverage.

- ☐ **Yes**, deduct from my pension.
- ☐ **No**, I will send my payment monthly. (You must make the first payment before you will be enrolled. Make check **payable to the Washington State Treasurer** and send with this form to Washington State Health Care Authority, P.O. Box 42695, Olympia, WA 98504-2695.

2013 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social security number
------------------------	------------	----------------	------------------------

Section 9: Signature *Required*

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we are eligible. To the extent permitted by law, PEBB may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.

If adding a domestic partner to my account, I declare that my partner and I have registered through the Washington Secretary of State's Office or another state.

If I send payment, this does not mean I will be automatically enrolled in PEBB insurance coverage. The PEBB Program will verify eligibility for me and my family members. If I am not enrolled in Medicare and apply to add a dependent to my PEBB coverage, I must provide copies of documents that verify the dependent's eligibility within PEBB's enrollment timelines or PEBB will not enroll him or her. If we do not qualify, I will receive a refund of premium payments.

I understand that if I enroll in retiree dental, I must remain enrolled in retiree dental for at least two years.

I understand if I or any enrolled family member is entitled to Medicare Part A and Part B, we must enroll and remain enrolled in Medicare Part A and Part B.

If I choose to defer medical/dental, I understand I can reenroll no later than **60 days** after losing other health coverage or during the annual open enrollment period with proof of continuous enrollment. If I defer enrollment for myself, I cannot enroll my eligible family members unless I defer to enroll in Medicare Part A and Part B and a Medicaid Plan that offers creditable coverage.

I can defer enrollment in a PEBB health plan for:

- Comprehensive, employer-sponsored medical plan as an employee or dependent, including insurance coverage continued under COBRA, that is not retiree coverage.
- Enrollment in Medicare Part A and Part B, and a Medicaid program that provides creditable coverage.
- Enrollment in medical coverage as a retiree or dependent in a federal retirement plan, such as TRICARE.
- Enrollment in a PEBB or Washington State K-12 school district-sponsored medical plan as a dependent.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that the PEBB Program will direct a portion of my monthly premium to an HSA based on the information I have provided, and that there are limits to these contributions and my HSA contributions, if any, under federal tax law.

If I die, my eligible surviving family members must complete an enrollment form to enroll in or defer PEBB retiree insurance coverage no later than **60 days** after my death.

This form replaces all *Retiree Coverage Election Forms* previously submitted to PEBB. If I previously elected retiree term life insurance it will remain in effect until I cancel it.

If you are a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share your information with the DRS to better serve you.

HCA's Privacy Notice: We will keep your information private as allowed by law. To receive our Privacy Notice, call 360-725-0442 or go to www.hca.wa.gov.

Subscriber's signature _____ Date _____

Be sure to sign and date this form. Return to:

Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684 or fax to: 360-725-0771

2013 PEBB MEDICAL CONTRACTORS

Group Health Cooperative, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Group Health Options, Inc., 320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 1-800-735-2900

Premiera Blue Cross, P.O. Box 327, Seattle, WA 98111-0327
1-800-817-3049 or TTY 1-800-842-5357

Uniform Medical Plan, administered by Regence BlueShield, P.O. Box 2998, Tacoma, WA 98401-2998
1-888-849-3681 or TTY 711

2013 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-650-1583

Uniform Dental Plan, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-537-3406

Willamette Dental of Washington, Inc., 6950 NE Campus Way, Hillsboro, OR 97124-5611
1-855-433-6825

2013 PEBB LIFE INSURANCE CONTRACTOR

ReliaStar Life Insurance Company, P.O. Box 20, Route 7325, Minneapolis, MN 55440-0020 (Policy Form #LP00GP)
1-866-689-6990